

# NaviCare<sup>®</sup>

## Pre-Enrollment Checklist

Before making an enrollment decision, it's important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-877-255-7108 (TRS 711), 8 a.m.–8 p.m., Monday–Friday (7 days a week, Oct. 1–March 31).

### Understanding the benefits

- The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It's important to review plan coverage, costs, and benefits before you enroll. Visit [fallonhealth.org/navicare](http://fallonhealth.org/navicare) or call 1-877-255-7108 (TRS 711) to view or request a copy of the EOC.
- Review the Provider Directory (or ask your doctor) to make sure the doctors you see now are in the network. If they're not listed, it means you'll likely have to select a new doctor.
- Review the Pharmacy Directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you'll likely have to select a new pharmacy for your prescriptions.
- Review the formulary to make sure your drugs are covered.

### Understanding important rules

- Benefits, premiums, and/or copayments/coinsurance may change on January 1, 2027.
- You must continue to pay your Medicare Part B premium unless the Commonwealth of Massachusetts pays this premium for you. This premium is normally taken out of your Social Security check each month.
- Except in emergency or urgent situations, we don't cover services by out-of-network providers (doctors who are not listed in the Provider Directory).
- This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on the following: 1) You must be age 65 or older, 2) You must have MassHealth Standard and Medicare Parts A and B, 3) you must live in the service area (all of MA, except Dukes and Nantucket counties), 4) You can't have any other comprehensive health insurance except Medicare.
- Effect on current coverage.** If you're currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have TRICARE, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact TRICARE for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you'll be paying for coverage you cannot use.



*NaviCare is a voluntary program in association with MassHealth/EOHHS and CMS.*

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This form is for people who have MassHealth Standard benefits and Medicare Parts A and B, and choose to enroll in NaviCare® HMO SNP.



# MassHealth Senior Care Options (SCO) & Medicare Advantage Enrollment Form

## MassHealth Information

► Are you enrolled in MassHealth? Yes  No

Please write in your MassHealth ID number or attach a copy of your MassHealth card. Your MassHealth number is the 12-digit number under your name. MassHealth ID number: \_\_\_\_\_

*You must be 65 years or older, have MassHealth Standard and Medicare Parts A and B benefits, live in the NaviCare service area, not have other comprehensive health insurance (except Medicare) and not be a resident of a chronic hospital, to enroll in a senior care organization.* To apply for MassHealth, call 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

► Name of primary care doctor you have selected: \_\_\_\_\_

## Member Information

Last name		First name		MI	Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/>
Date of birth	Preferred format for materials <input type="checkbox"/> Braille <input type="checkbox"/> Large print <input type="checkbox"/> Audio CD* <input type="checkbox"/> Data CD <input type="checkbox"/> Other _____				
*Audio messages will not be encrypted, which means they could be intercepted by others. By selecting audio, you agree to receive these audio messages without encryption.					
Sex M <input type="checkbox"/> F <input type="checkbox"/>	Written language preferred		Spoken language preferred		

## Permanent address (where you live)

Street address		City/town	
State	ZIP	Home phone number	
Mobile phone number (optional) (____) _____ - _____		Email address (optional) _____	
<input type="checkbox"/> I authorize Fallon Health to send me text messages related to my plan benefits and services.		<input type="checkbox"/> I authorize Fallon Health to send me email messages related to my plan benefits and services.	

**Mailing address** (where you get mail, if different from where you live)

Street address		City/town
State	ZIP	Telephone number

If you are a resident of a **nursing facility**, enter the name and address here.

Name of nursing facility		
Street address		City/town
State	ZIP	Telephone number

**Medicare Information**

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▶ Please take out your red, white, and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

- OR -

- Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.

**You must have Medicare Part A and Part B to join a Medicare Advantage plan.**

Name (as it appears on your Medicare card): _____	
Medicare Number: _____	
Is entitled to:	Effective date:
<input type="checkbox"/> HOSPITAL (Part A) _____	
<input type="checkbox"/> MEDICAL (Part B) _____	

**Other Health Insurance**

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▶ **Do you have any health insurance other than Medicare and MassHealth?** Yes  No

If you answered yes, what is the name of the other insurance? \_\_\_\_\_

## Your Medical Care

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By completing this enrollment application, I agree to the following:

\_\_\_\_\_ NaviCare \_\_\_\_\_ is a Coordinated Care plan with a Medicare contract and a contract with the Commonwealth of Massachusetts Medicaid program. Enrollment in the plan depends on the plan's contract renewal with Medicare. This plan is a voluntary program that is available to anyone 65 and older who qualifies for MassHealth Standard and Original Medicare and does not have any other comprehensive health insurance, except Medicare. I will need to keep my MassHealth Standard and my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Because I have MassHealth and Medicare Parts A and B, I may leave \_\_\_\_\_ NaviCare \_\_\_\_\_ any time. I will no longer be covered by \_\_\_\_\_ NaviCare \_\_\_\_\_ on the first day of the month following the month I request to leave \_\_\_\_\_ NaviCare \_\_\_\_\_. (Example: I request to leave this plan on July 10; I am no longer covered by this plan on August 1.)

\_\_\_\_\_ NaviCare \_\_\_\_\_ serves a specific service area. If I move out of the area that \_\_\_\_\_ NaviCare \_\_\_\_\_ serves, I need to notify the plan so that I can disenroll and find a new plan in my new area. Once I am a member of \_\_\_\_\_ NaviCare \_\_\_\_\_, I have the right to appeal plan decisions about payment or services if I disagree with them. I will read the Evidence of Coverage from \_\_\_\_\_ NaviCare \_\_\_\_\_ when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date that \_\_\_\_\_ NaviCare \_\_\_\_\_ coverage begins, I must get all my health care from \_\_\_\_\_ NaviCare \_\_\_\_\_ with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by \_\_\_\_\_ NaviCare \_\_\_\_\_ and other services contained in my \_\_\_\_\_ NaviCare \_\_\_\_\_ Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR \_\_\_\_\_ NAVICARE \_\_\_\_\_ WILL PAY FOR THE SERVICES.

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with \_\_\_\_\_ NaviCare \_\_\_\_\_, he or she may be compensated based on my enrollment in \_\_\_\_\_ NaviCare \_\_\_\_\_.

## Release of Information

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By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that \_\_\_\_\_ NaviCare \_\_\_\_\_ will release my information to Medicare, who may release it for research and other purposes that follow all applicable federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the state where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under state law to complete this enrollment and 2) documentation of this authority is available upon request by \_\_\_\_\_ NaviCare \_\_\_\_\_ or by Medicare.

***One of our Enrollee Service Representatives will be calling you within the next 10 days to verify the information on this form and to make sure you understand our plan rules.***

***Please provide a telephone number we may use for that call:*** \_\_\_\_\_

***Best time to call:*** \_\_\_\_\_ *morning* \_\_\_\_\_ *afternoon* \_\_\_\_\_ *evening*

**Signature**

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Signature: \_\_\_\_\_

Print name: \_\_\_\_\_

Today's date: \_\_\_\_\_

If you have chosen an authorized representative, the authorized representative must sign above and provide the following information.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Primary phone number: \_\_\_\_\_

Relationship to enrollee: \_\_\_\_\_

**Office Use Only**

Date received: \_\_\_\_\_

Name of staff member/agent/broker (*if assisted in enrollment*):  
\_\_\_\_\_

Broker/agent name: \_\_\_\_\_ Mass. Lic#: \_\_\_\_\_

National Producer Number (brokers/agents only): \_\_\_\_\_

Plan ID No: \_\_\_\_\_

Effective date of coverage: \_\_\_\_\_

ICEP/IEP: \_\_\_\_\_ OEP: \_\_\_\_\_ AEP: \_\_\_\_\_

SEP (type): \_\_\_\_\_ Not Eligible: \_\_\_\_\_

**Notes**

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